Supreme Court, U.S.
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No. 99-

IN THE

Supreme Court of the United States

RITA MORENO GALLEGOS,

Petitioner,

v.

MT. SINAI MEDICAL CENTER and
UNUM LIFE INSURANCE COMPANY OF AMERICA,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the decision of the United States Court of Appeals for the Seventh Circuit is in irreconcilable conflict with *UNUM Life Insurance Company v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999) which ruled that internal reviews of ERISA benefit claims would be enhanced by consideration of ostensibly late-filed appeals so long as the plan administrator does not suffer prejudice due to the late filing?

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Petitioner respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit issued in this matter on April 27, 2000, and upon which rehearing was denied on May 26, 2000. Petitioner seeks the issuance of a writ of certiorari on the ground that the Seventh Circuit's decision irreconcilably conflicts with this Court's ruling in *UNUM Life Insurance Company v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999). In *Ward*, this Court recognized that late submission of ERISA (Employee Retirement Income Security Act — 29 U.S.C. § 1001 *et seq.*) claims is excusable where no prejudice is suffered by the other party. The Court also approved an extension of its ruling to reviews requested pursuant to ERISA § 503 (29 U.S.C. § 1133), finding: "By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." 526 U.S. at 377, 119 S. Ct. at 1391. In this action, which squarely presented the issue of *Ward's* applicability to an ostensibly late-filed administrative appeal, the Court of Appeals completely ignored the issue and refused to consider *Ward* in any respect. Given the wide breadth and scope of the ERISA law and its application to all privately sponsored employee benefit plans, this is an issue of great national importance.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit, issued on April 27, 2000, is published at 210 F.3d 803 (7th Cir. 2000) and is reprinted in the Appendix hereto as App. A, at 1a. A petition for rehearing or rehearing *en banc* was denied on May 26, 2000, and appears in Appendix C, at 40a. The opinion of the United

States District Court for the Northern District of Illinois is electronically published at 1999 U.S. Dist. LEXIS 4800; 60 Soc. Sec. Rep. Service 673 and is reprinted in Appendix B, at 16a.

JURISDICTIONAL STATEMENT

The district court had jurisdiction over this matter pursuant to 28 U.S.C. § 1331, as well as 29 U.S.C. §§ 1132(e) and (f). An appeal was taken to the United States Court of Appeals for the Seventh Circuit pursuant to 28 U.S.C. § 1291. The judgment of the Court of Appeals was rendered on April 27, 2000. Petitioner sought rehearing by the panel, or alternatively, rehearing *en banc*. That request was denied on May 26, 2000. The jurisdiction of the Supreme Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 503 of ERISA, 29 U.S.C. § 1133, states in relevant part:

> In accordance with regulations of the Secretary, every employee benefit plan shall —
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

STATEMENT OF THE CASE

Rita Gallegos was born on November 30, 1942. She was employed by the Mt. Sinai Hospital Medical Center/Sinai Family Health Center from 1990 until 1994 as "Director of Marketing," a job that required her to travel throughout the Chicago area to market medical services within the community. In 1992, Mrs. Gallegos received treatment for breast cancer. Because her illness and treatment kept her from working for more than one year, she qualified for Social Security disability benefits. Mrs. Gallegos's condition then sufficiently remitted to enable her to return to work in June 1993, but she had to stop working again in 1994 as a result of additional severe medical problems: congestive heart failure, chronic obstructive pulmonary disease, chronic active hepatitis C, and residual systemic impairments resulting from chemotherapy treatment for breast cancer.

Then, in 1995, Mrs. Gallegos applied for disability benefits from the long-term disability insurer that underwrote coverage for employees of Mt. Sinai Hospital, UNUM Life Insurance Company of America. UNUM reviewed the claim and approved an award of benefits, noting a return to work was unlikely due to the severity of organ damage suffered by Mrs. Gallegos. UNUM then commenced monthly disability benefit payments coordinated with Social Security disability benefits that remained ongoing from the prior period of disability.

In early 1996, UNUM received an updated report on Mrs. Gallegos's condition from her treating doctor who advised the insurer she would need "new lungs, a new heart, and a new liver to return to work." However, when Mrs. Gallegos notified UNUM shortly thereafter that Social Security had terminated benefit payments on account of her return to work,

UNUM suddenly ceased paying benefits as well, writing to her on June 11, 1996 that UNUM considered her capable of performing a sedentary job. The letter further stated that if Mrs. Gallegos disagreed with UNUM's decision, she could appeal the decision by writing to UNUM's "LTD Quality Review Section" within sixty days.

Mrs. Gallegos did not contact UNUM, though, for several months. In late March 1997, the Social Security Administration again found her disabled and reinstated payment of disability benefits. Mrs. Gallegos immediately notified UNUM of the Social Security approval and requested that her claim be reopened. Soon thereafter, her attorney submitted additional evidence and argument supporting benefit reinstatement. UNUM refused to reconsider, though, contending it was not required to consider an appeal submitted more than sixty days after notification of the benefit termination. Litigation ensued.

In the district court, UNUM was granted summary judgment, with the court determining that Mrs. Gallegos was barred from seeking review due to her failure to submit an appeal within sixty days of the benefit termination. The court also declined to remand the case to allow the appeal to go forward, ruling, "by ordering either remand or dismissal without prejudice, this court would effectively eliminate the 60-day deadline for appeals." App. B at 37a.

Mrs. Gallegos appealed the lower court ruling to the United States Court of Appeals for the Seventh Circuit, contending, among other things, that the district court's opinion was contrary to this Court's ruling in *UNUM Life Insurance Company v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999). Mrs. Gallegos asserted that in the

absence of a showing of actual prejudice, UNUM was obliged to consider Petitioner's appeal. In its decision, the Court of Appeals agreed with one of Mrs. Gallegos's arguments — the court ruled that communications to Gallegos regarding a sixty day deadline were ambiguous and confusing, thus giving claimants the option of either appealing or filing suit. App. A at 13a. However, the court found that because Mrs. Gallegos could not show she was misled by the confusing language, she was nonetheless bound by the deadline.

Although Mrs. Gallegos argued that this Court's decision in *Ward* had an essential bearing on her appeal, the Court of Appeals ignored that argument and upheld the lower court's ruling. The court of appeals subsequently refused a request for rehearing seeking consideration of *Ward's* applicability.

REASONS FOR GRANTING THE WRIT

THE SEVENTH CIRCUIT'S COMPLETE DISREGARD OF *UNUM v. WARD* RESULTED IN A RULING THAT IRRECONCILABLY CONFLICTS WITH WARD

The Seventh Circuit's decision completely ignores *UNUM Life Insurance Company v. Ward* which gave explicit direction to lower courts regarding the issue presented in this case. As a result, *Gallegos v. UNUM* irreconcilably conflicts with *Ward.*

Prior to filing suit, Mrs. Gallegos requested that UNUM review the termination of her disability benefit payments in accordance with ERISA § 503 (29 U.S.C. § 1133). Her appeal presented overwhelming evidence proving her benefit entitlement. Due to severe cardiac, pulmonary, hepatic and

systemic impairments, Petitioner argued she could not return to her regular occupation which UNUM mischaracterized as "sedentary" as its basis for terminating benefits. However, UNUM refused to consider Petitioner's appeal, claiming the filing was made outside of a 60 day appeal deadline, which the ERISA claim regulations state is a minimum period for submitting such claims. 29 C.F.R. § 2560.503-1(d).

In moving for summary judgment, UNUM asserted the sanctity of the 60 day deadline for appeals; however, UNUM's insistence on such a short appeal deadline is puzzling because Respondent allows up to one year to submit proof of a new disability claim; and Mrs. Gallegos submitted her review request well within that period. UNUM also failed to demonstrate any particular prejudice suffered as a result of the claimed late filing. Nonetheless, the district court agreed with UNUM and entered judgment under a mistaken belief that a sixty day appeal deadline acted as a statute of limitations. The court of appeals then refused to overturn that ruling even though it found the so-called deadline was not mandatory.

Although the arguments made by UNUM in opposition to Mrs. Gallegos's claims were the same arguments that were rejected in *Ward*, the courts below failed to recognize the fallacy in their rulings. On the precise issue presented here, this Court ruled:

> Finally, we reject UNUM's suggestion that the notice-prejudice rule conflicts with § 503 of ERISA, 29 U.S.C. § 1133, which requires plans to provide notice and the opportunity for review of denied claims, or with the Department of Labor regulations providing that "[a] claim is filed when

> the requirements of a reasonable claim filing procedure . . . have been met," 29 C.F.R. § 2560.503-1(d)(1988). By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations.

526 U.S. at 377, 119 S. Ct. at 1391. Because the Seventh Circuit completely ignored that portion of the *Ward* ruling, its decision conflicts with *Ward*. As a result, the Seventh Circuit's failure to adhere to this Court's ruling requires the granting of certiorari. The issue resolved in *Ward* has importance to the millions of employees and their dependents who rely on employer-sponsored health, life, and disability benefits. By ignoring *Ward*, the court of appeals has subjected unknowing claimants to what effectively constitutes a sixty-day statute of limitations that will undoubtedly result in unjust forfeitures of necessary medical services or essential financial benefits. Thus, the *Gallegos* ruling, which conflicts with *Ward*, cannot stand.

The prevention of inequitable forfeitures of benefits was the main justification behind the principle of insurance law applied in *Ward*, upholding the maxim that "the law abhors a forfeiture." 526 U.S. at 370-1, 119 S. Ct. at 1387-8. However, by not giving any consideration to the *Ward* ruling, the precise inequity that *Ward* intended to prevent was perpetuated. Further, in addition to upholding an inequitable forfeiture of benefits, the court of appeals also ignored the primary intent behind the ERISA law as recognized in *Varity Corp. v. Howe*, 516 U.S. 489, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996). *Howe* reiterated ERISA's purpose is to protect "the interests of participants in employee benefit plans and

their beneficiaries" (citing 29 U.S.C. § 1001(b)). Instead of promoting ERISA's goals by enabling consideration of a meritorious benefit appeal, the court of appeals allowed ambiguous procedural considerations to justify an unjust forfeiture of benefits. Because such an outcome runs contrary both to the intent of the ERISA law as well as this Court's *Ward* decision, this petition should therefore be granted.

CONCLUSION

This case presents a question of exceptional importance that was simply overlooked by the court of appeals. Despite the clear direction issued by this Court in *Ward*, the court below failed to consider whether UNUM had the authority, in the absence of prejudice shown, to reject Petitioner's meritorious request for administrative review of her terminated benefit claim simply because of a missed sixty day filing deadline. This Court should therefore grant this petition for certiorari and order a reexamination of the appellate decision in light of *Ward*.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DECIDED APRIL 27, 2000

Rita Moreno Gallegos, Plaintiff-Appellant, v. Mt. Sinai Medical Center and UNUM Life Insurance Company of America, Defendants-Appellees.

No. 99-2022

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

2000 U.S. App. LEXIS 8172

January 6, 2000, Argued

April 27, 2000, Decided

OPINION:

Flaum, Circuit Judge. Rita Moreno Gallegos was an employee of Mt. Sinai Medical Center ("Mt. Sinai") who applied for employee welfare benefits with Mt. Sinai's insurance carrier UNUM Life Insurance Company of America ("UNUM"). Her request for benefits was denied, and Gallegos filed suit, claiming that this denial violates the Employee Retirement Insurance Security Act ("ERISA"), *29 U.S.C. sec. 1001,* et seq. The district court granted summary judgment to the defendants. For the reasons stated below, we affirm.

Appendix A

I. BACKGROUND

Gallegos was employed by Mt. Sinai as a marketing director from 1990 until 1994. Her job responsibilities included coordinating health fairs and conducting other marketing activities in the community. As part of her job she had to travel frequently throughout the surrounding area, carry and set-up display equipment, and stand for significant periods of time.

Gallegos was insured under Mt. Sinai's Employee Long Term Disability Plan (the "Plan"). Gallegos's policy (the "Policy") was administered by Mt. Sinai and underwritten by UNUM. The Policy provides long-term disability benefits for employees who meet the Plan's requirements. The Plan does not indicate that there are any time limits for appealing denials of claims. However, the summary plan description ("Summary Plan") contains the following statements:

> What are your rights under ERISA?
>
> * * * *
>
> 5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.
>
> 6. . . . . If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. . . . The court

will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.[1]

What if your claim is denied?

In the event that your claim is denied, either in full or in part, the insurance company will notify you in writing within 90 days after your claim form was filed. . . . The insurance company's notice of denial shall include:

* * *

3. The steps to be taken if you or your beneficiary wish to have the decision reviewed.

What do you do to appeal?

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the insurance company's notice of denial. . . .

---

1. The Plan provides the following information: Can legal proceedings be started at any time? No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor

2. more than 3 years after the time proof of claim is required.

Appendix A

On December 16, 1994, Gallegos stopped working because she suffered from multiple severe medical conditions including congestive heart failure, chronic obstructive pulmonary disease, chronic active hepatitis C, and residual systemic complications resulting from the chemotherapy treatment she had received for breast cancer two years earlier. On July 6, 1995, after it became apparent that Gallegos would not be able to return to work, Gallegos made a timely application for disability benefits under the Plan. This application was accompanied by a statement from Gallegos's physician Dr. Benson stating that Gallegos's illnesses prevented her from performing any non-sedentary occupation. The application also included a job description provided by Mt. Sinai indicating that Gallegos's current position as director of marketing frequently required her to travel, stand, walk and lift or carry equipment weighing 25-50 pounds.

UNUM initially approved Gallegos's application for disability benefits on August 15, 1995. UNUM awarded Gallegos monthly benefits equivalent to the amount specified in the Policy minus the amount that Gallegos was receiving in Social Security benefits. Gallegos's Social Security benefits were terminated in October 1995. On November 7, 1995, Gallegos reapplied for Social Security benefits. On November 8, 1995, Gallegos informed UNUM that her Social Security benefits had been terminated and requested that her UNUM insurance disbursement be increased to the full amount she was entitled to receive because the amount she had previously received from Social Security should no longer be deducted. On January 25, 1996, the Social Security Administration ("SSA") denied Gallegos's reapplication for benefits, and Gallegos appealed this decision.

Appendix A

On March 7, 1996, UNUM telephoned Gallegos to assess the status of her Social Security appeal, and Gallegos informed UNUM that there had been no ruling as of that date. On March 14, 1996, UNUM requested an update from Dr. Benson on Gallegos's medical status. On May 13, 1996, UNUM received a letter and medical records from Dr. Benson that stated that in order for Gallegos to return to work she would need "new lungs, a new heart and a new liver." Dr. Benson again stated that Gallegos was able to perform only sedentary work. The medical records that accompanied the letter indicated that Gallegos's condition had worsened since she had stopped working in 1994.

On June 11, 1996 UNUM wrote to Gallegos (the "June 11 Letter"), informing her that it was terminating her disability benefits because it had determined that her occupation of "Marketing Director" was a sedentary occupation to which she was eligible to return according to the information provided by Dr. Benson. The June 11 Letter included the following statements:

> If you have any new, additional information to support your request for disability benefits, please send it to [UNUM's] attention at the above address.
>
> If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice. . . .

> If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

On April 10, 1997, an SSA administrative law judge ("ALJ") issued a decision determining that Gallegos was disabled as of December 16, 1994, and reinstating her Social Security benefits. On April 18, 1997, Gallegos's attorney wrote to UNUM providing notice of the ALJ's decision reinstating Gallegos's Social Security benefits. In this April 18 letter, her attorney noted that the 60-day review period had passed but indicated that the additional information was only recently available and could not have been provided to UNUM before the expiration of the deadline.

On July 9, 1997, Gallegos's attorney again wrote to UNUM requesting that UNUM reopen Gallegos's claim based on the ALJ's determination that Gallegos was disabled and the attorney's contention that Gallegos's occupation was more appropriately categorized as "public health educator," a non-sedentary position, rather than "marketing director," a sedentary one. On July 31, 1997, UNUM responded in writing that it would not reopen Gallegos's claim because she had made her request for review more than 60 days after the denial of benefits.

Gallegos filed suit in federal district court alleging that UNUM wrongfully denied her benefits in violation of *29 U.S.C. sec. 1132*(a)(1)(B). The district court entered summary judgment in favor of UNUM, finding that Gallegos had failed to exhaust her administrative remedies by not filing for a review of her claim within the 60-day deadline outlined in the Summary Plan. Gallegos now appeals.

II. DISCUSSION

The text of *29 U.S.C. sec. 1132*, providing for civil actions to redress violations of ERISA, does not address whether a claimant must exhaust her administrative remedies before filing suit in federal court. See *Powell v. AT&T Comm., Inc., 938 F.2d 823, 825 (7th Cir. 1991); Kross v. Western Elec. Co., Inc., 701 F.2d 1238, 1244 (7th Cir. 1983).* However, it has long been recognized in this Circuit that the intent of Congress is best effectuated by granting district courts discretion to require administrative exhaustion. See *Powell, 938 F.2d at 825; Kross, 701 F.2d at 1244.* This policy of judicial administration furthers the goals of minimizing the number of frivolous lawsuits, promoting non-adversarial dispute resolution, and decreasing the cost and time necessary for claim settlement. See *Lindemann v. Mobil Oil Corp., 79 F.3d 647, 649 (7th Cir. 1996).* Furthermore, requiring administrative exhaustion enables the compilation of a complete record in preparation for judicial review. See id.; *Powell, 938 F.2d at 826.* Therefore, the district court in this case had the discretion to require that Gallegos exhaust the administrative remedies available to her before being permitted to bring suit in federal court under *29 U.S.C. sec. 1132.* We will overturn the district court's decision in this matter only for a clear abuse of discretion. See *Ames v. American Nat'l Can Co., 170 F.3d 751, 756 (7th Cir. 1999); Powell, 938 F.2d at 825; Kross, 701 F.2d at 1244.* An abuse of discretion is "a serious error of judgment, such as reliance on a forbidden factor or failure to consider an essential factor." *Powell, 938 F.2d at 825.*

Appendix A

A. Excuse of Failure to Exhaust

We have held that a plaintiff is excused from failing to pursue administrative remedies where 1) administrative remedies are not available or 2) pursuing those remedies would be futile. See *Robyns v. Reliance Standard Life Ins. Co., 130 F.3d 1231, 1236 (7th Cir. 1997); Wilczynski v. Lumbermens Mutual Casualty Co., 93 F.3d 397, 402 (7th Cir. 1996); Smith v. Blue Cross & Blue Shield United of Wisc., 959 F.2d 655, 658-59 (7th Cir. 1992).*[2] Gallegos does not assert that attempts to pursue administrative review would have been futile. However, Gallegos claims that administrative review procedures were not adequately provided to her. Gallegos argues that the denial of her application as time barred is a denial of access to review that should excuse her from having to exhaust her administrative remedies.

ERISA regulations permit time limitations on applications for review that are no less than 60 days. 29 C.F.R. sec. 2560.503-1(g)(3). Failure to file a request for review within this limitations period is one means by which a claimant may fail to exhaust her administrative remedies. See *Smith, 959 F.2d at 658.* UNUM provided a clear statement of the limitations period in both the Summary Plan and in the June 11 Letter. This statement is sufficient to satisfy ERISA's notice requirement for review procedures. See *Ames, 170 F.3d at 756.* Thus, UNUM's denial of

2. Gallegos raised before the district court several other reasons why administrative exhaustion should not be applied in her case. Gallegos does not argue those additional contentions on appeal, and we consider them waived.

Gallegos's request for review that was filed beyond the 60-day time limit does not constitute a denial of access to administrative review. See id.

B. Estoppel

Gallegos next argues that UNUM should be estopped from asserting her failure to exhaust administrative remedies as a defense to her suit in federal court. Gallegos argues that statements in the Summary Plan and June 11 Letter are misleading in that a plain reading conveys to the average participant that UNUM's administrative review procedure is wholly voluntary and does not affect the ability of a participant to pursue relief through the federal court system. Gallegos contends that the two options for review of her denied claim were presented as co-equal, not interdependent. She argues that because UNUM provided misleading information in the Summary Plan and the June 11 Letter concerning the effects of failing to file an administrative appeal, UNUM should now be estopped from asserting failure to exhaust administrative remedies as a defense to her suit under ERISA.

This Court has repeatedly held that estoppel may be applied in certain ERISA actions. See *Coker v. Trans World Airlines, Inc., 165 F.3d 579, 585 (7th Cir. 1999)* ("This court . . . has recognized a form of estoppel as a matter of federal common law in at least some ERISA cases."); *Thomason v. Aetna Life Ins. Co., 9 F.3d 645, 649-50 (7th Cir. 1993); Russo v. Health, Welfare & Pension Fund, 984 F.2d 762, 767 (7th Cir. 1993); Vershaw v. Northwestern Nat'l Life Ins. Co., 979 F.2d 557, 559 (7th Cir. 1992); Black v. TIC Investment*

Corp., 900 F.2d 112, 112 (7th Cir. 1990). When determining whether to apply estoppel, we have considered ERISA's prohibition against oral modifications of written plans and have determined that estoppel in the ERISA context only applies to written, and not to oral, misrepresentations. See *Thomason, 9 F.3d at 649-50; Decatur Mem'l Hosp. v. Connecticut Gen. Life Ins. Co., 990 F.2d 925, 927 (7th Cir. 1993); Russo, 984 F.2d at 767.* In addition, while we have determined that estoppel may be applied to single-employer unfunded plans, we have expressed reservations about employing estoppel in other contexts. See *Black, 900 F.2d at 115* (stating that concerns for the actuarial soundness of multi-employer funded plans may militate against applying estoppel in that context).

The determination of when to apply estoppel "is not so much a question of statutory interpretation as a question of public policy." *Black, 900 F.2d at 114.* The basic policy consideration arguing in favor of applying estoppel is the principle of contract law that "a party who prevents the occurrence of a condition precedent may not stand on that condition's non-occurrence to refuse to perform his part of the contract." *Swaback v. American Info. Techs. Corp., 103 F.3d 535, 542 (7th Cir. 1996).* We have applied estoppel principles to ERISA claims where the claimant was misled by written representations of the insurer or plan administrator into failing to take an action that would have enabled the claimant to receive benefits under the Plan. See *id. at 542-43* (holding that a claimant could proceed with an ERISA suit in federal court in spite of his failure to timely elect a lump-sum pension payment because his failure to elect was a result of the insurer's erroneous written statements that

the claimant was ineligible to receive this type of payment); *Meredith v. Allsteel, Inc., 11 F.3d 1354, 1358 (7th Cir. 1993)* (finding that employees who failed to timely elect early retirement benefits were not barred from suit in federal court where their failure to elect was caused by the employer's misrepresentation that they were ineligible to receive those benefits), overruled on other grounds by *Ahng v. Allsteel, Inc., 96 F.3d 1033 (7th Cir. 1996)*. We have also applied estoppel in an ERISA suit where the defendant insurer misrepresented the contractual limitations period in the plan summary because we determined that "a defendant whose own activities made the plaintiff miss the deadline should [not] be allowed to litigate over whether the plaintiff could have sued earlier." *Doe v. Blue Cross & Blue Shield United of Wisc., 112 F.3d 869, 876 (7th Cir. 1997)*.

The administrative exhaustion requirement is not intended to place a meaningless procedural hurdle in front of plaintiffs who desire to bring claims for violations of their rights under ERISA in federal court. Such a purpose would contravene the express intent of the ERISA statute to "protect . . . the interests of participants in employee benefits plans . . . by . . . providing . . . ready access to the Federal courts." *29 U.S.C. sec. 1001*(b). Rather, the requirement is aimed at encouraging claimants to pursue private remedies and develop a proper administrative record before entering federal court. Allowing an insurance company to mislead a claimant into procedurally defaulting her opportunity for administrative review would contravene the purpose behind requiring administrative exhaustion. Furthermore, where a limitations period is imposed by a contract rather than by statute, the public policy considerations that typically weigh

in favor of strict enforcement of the limitations period do not apply. See *Doe, 112 F.3d at 877.* This is especially true where one of the parties to the agreement "does something that makes it inequitable to hold the other party to the shortened period" because then "there is no social interest in preventing the period from being enlarged." Id. Therefore, we hold that estoppel may be applied to preclude the assertion of failure to exhaust administrative remedies as a defense where that failure results from the claimant's reliance on written misrepresentations by the insurer or plan administrator.[3]

In this case, Gallegos alleges that UNUM made misleading representations in the Summary Plan and June 11 Letter concerning the consequences of her failure to pursue an administrative appeal. We interpret an ERISA plan summary with its plain meaning as understood by an average person. See *29 U.S.C. sec. 1022*(a) ("The summary plan description . . . shall be written in a manner calculated to be understood by the average plan participant."); *Swaback, 103 F.3d at 540-41.* ERISA summary plan descriptions are required to be "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." *29 U.S.C. sec. 1022*(a). This description must include "the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures [for administrative review])." *29 U.S.C. sec. 1022*(b); see *29 U.S.C. sec. 1021*(a).

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3. For purposes of this opinion, we assume that this case involves a single-employer unfunded plan, and we again decline to reach the question of whether estoppel may be applied outside of this context.

In this case, UNUM attempted to comply with the requirements of ERISA by informing Gallegos of her options to pursue relief of the denial of her claim through UNUM's administrative review procedure as well as through the federal court system. Gallegos asserts, however, that what UNUM did not tell her was that if she elected not to pursue an administrative review of her claim, UNUM would use this choice as a defense against her in any subsequent federal suit. We agree with Gallegos that the use of phrases such as "you may have [your claim] reviewed," "should you desire a review," "if you . . . wish to have the decision reviewed," and "you . . . may appeal," given their plain meaning, indicate that a plan participant has the opportunity to participate in a voluntary, rather than mandatory, review procedure. The only penalty mentioned for failure to submit to administrative review is that the claims decision will become "final." There is no indication that this "finality" may have consequences for the bringing of a suit in federal court, an option which the claimant is also informed she "may" pursue. A natural reading of the plain language of the Summary Plan and June 11 Letter is that both a court suit and an administrative appeal are voluntary options for review of a denial of a claim. The administrative appeal has a limitations period of 60 days from the denial of the claim, and the limitations period for a court suit, while not defined in the Summary Plan, is stated in the Plan as three years from the time when proof of a claim is required.

In Black v. TIC Investment Corp., we held that a plan administrator's written representation to the claimant that his benefits would be forthcoming upon completion of bankruptcy proceedings estopped the administrator from

contesting the claim because "no fair reading of the language would give a casual reader notice that [the defendant] intended to contest any claim." *900 F.2d at 116.* We concluded that if the claimant could demonstrate that he relied to his detriment on the defendant's implied representation that it would not contest his claim to benefits, the defendant was estopped from contesting the claim. Id. Similarly, in this case, a casual reader of the Summary Plan would not be put on notice that an insured's election not to pursue administrative remedies would be used by UNUM as a defense to a suit brought in federal court.

However, "an estoppel arises when one party has made a misleading representation to another party and the other has reasonably relied to his detriment on that representation." *Black, 900 F.2d at 115;* see *Russo, 984 F.2d at 768; Thomason, 9 F.3d at 648.* Thus, Gallegos must also demonstrate that she relied to her detriment on UNUM's representations. See *Swaback, 103 F.3d at 543* (finding that a claimant must show that "but for" the misrepresentations of the insurer he would have met the deadline imposed by the insurance contract). Gallegos must show that, based upon the representations made by UNUM, she thought that the two options for reviewing the denial of her claim—a federal court suit or an administrative appeal—were equally available to her, and she must also show that she chose to pursue the route of a court suit rather than administrative review, unaware that this choice was potentially fatal to her ability to receive any review of the denial of her claim.

We conclude that Gallegos has not demonstrated that she relied on UNUM's representations to her detriment because she has not shown that but for UNUM's representations she would have filed an administrative appeal within the 60-day

limitations period. Gallegos asserts that she was unrepresented by counsel at the time her claim was denied, and, therefore, that she was unable to know that one of the potential consequences of failing to pursue an administrative appeal was that she may also be barred from bringing suit to assert her rights under ERISA. However, she does not allege that she allowed the time for her appeal to lapse because she had chosen to pursue relief from the denial of her claim through a federal court suit rather than administrative review. If anything, Gallegos's contentions support the conclusion that during the 60-day limitations period she elected not to appeal her claim at all, not that she elected to pursue an avenue of relief with a longer statute of limitations.

We find that while the presentation of the options for review of denied claims in UNUM's Summary Plan and June 11 Letter was misleading, Gallegos did not rely on any of UNUM's misleading statements in deciding not to pursue an administrative appeal within the 60-day deadline. Therefore, UNUM is not estopped from asserting failure to exhaust administrative remedies as a defense to Gallegos's suit in federal court, and the district court did not abuse its discretion by granting summary judgment to UNUM on this basis.

III. CONCLUSION

For the reasons stated herein, we Affirm the district court's grant of summary judgment in favor of the defendant.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION DECIDED MARCH 31, 1999

RITA MORENO GALLEGOS, Plaintiff, v. MT. SINAI MEDICAL CENTER and UNUM LIFE INSURANCE COMPANY OF AMERICA, Defendants.

No. 97 C 6207

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

1999 U.S. Dist. LEXIS 4800; 60 Soc. Sec. Rep. Service 673

March 31, 1999, Decided

March 31, 1999, Docketed

OPINION:

MEMORANDUM OPINION AND ORDER

Plaintiff Rita Moreno Gallegos has brought this action alleging that defendants Mt. Sinai Medical Center and UNUM Life Insurance Company of America wrongfully denied her long-term disability (LTD) benefits, in violation of § 502(a)(1)(B) of the Employee Retirement and Income Security Act (ERISA), *29 U.S.C. § 1132*(a)(1)(B). Gallegos and the defendants have filed cross-motions for summary judgment. For the reasons set forth below, the defendants' motion for summary judgment is granted and Gallegos's motion for summary judgment is denied.

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BACKGROUND

Gallegos was employed as Director of Marketing for Mt. Sinai from December 1990 until December 16, 1994. As a benefit of her employment, Gallegos was insured under Mt. Sinai's Employee Long Term Disability Plan (the Plan). The Plan is an employee welfare benefit plan within the meaning of *29 U.S.C. 1002,* et seq. Mt. Sinai is designated as Plan Administrator under the Plan. The Plan was insured by UNUM through UNUM policy number 395401 (the Policy).

Benefits under the Plan are equal to two-thirds of monthly compensation, subject to certain offsets such as social security disability (SSDI) benefits. As of December 1994, Gallegos was earning $ 3,575.53 per month.

The Policy provides benefits for employees who meet the Plan's requirements. The policy states:

> When the Company receives proof that an insured is disabled due to sickness or injury and requires the regular attendance of a physician, the Company will pay the insured a monthly benefit after the end of the elimination period. The benefits will be paid for the period of disability if the insured gives to the Company proof of continued:
>
> 1. disability; and
>
> 2. regular attendance of a physician.

(Fohlin Aff. Ex. 2 at CL232.) The Policy defines disability as follows:

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"Disability" and "disabled" mean that because of injury or sickness:

> 1. The insured cannot perform each of the material duties of his regular occupation; and
>
> 2. After benefits have been paid for 24 months, the insured cannot perform each of the material duties of any gainful occupation for which he is reasonably fitted, taking into consideration training, education or experience, as well as prior earnings.

(Id. at CL230.)

Gallegos suffers from numerous health problems. She suffers from congestive heart failure and ventricular arrhythmia. She suffers from hepatitis C, emphysema and an enlarged heart. She had breast cancer in 1992-93 from which she still experiences some swelling in her right arm. She suffers from chronic obstructive pulmonary disease. She has heart palpitations and shortness of breath.

On August 1, 1995, UNUM received a claim from Gallegos for LTD benefits under the Policy. Although Gallegos did not answer the question "Why are you unable to work?", she did report that she suffered from shortness of breath, fatigue, and strong palpitations and that she had been unable to sleep. She stated that her symptoms had become "unmanageable and worse since 12/94." She indicated that she did not expect to return to work.

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Gallegos's application included a form from her attending physician, Dr. Eric Benson, completed on July 6, 1995. Dr. Benson listed as restrictions or limitations that Gallegos could work at a sedentary job only and could not perform heavy lifting, climb stairs, or stand for a prolonged period. Dr. Benson's response to the question "What is your prognosis for recovery?" is partially illegible. Plaintiff argues that he wrote "Recovery — poor" but it is unclear if he wrote the word "poor." He also reported that Gallegos "should be able to maintain function with medical." Dr. Benson indicated that Gallegos had not achieved "maximum medical improvement," that he expected her to do so within 3-4 months, and that he was "awaiting maximal efficiency of medical management by 10/95."

Gallegos's application also included a form completed by Mt. Sinai, her employer. Mt. Sinai listed her job as "Director of Marketing." Mt. Sinai indicated that Gallegos's Director of Marketing position required her to spend 25 to 50 percent of her time traveling within the City of Chicago and frequently required her to stand, walk, sit, and lift/carry equipment weighing 25-50 pounds.

On August 15, 1995, UNUM approved Gallegos's application for benefits. UNUM began paying Gallegos a monthly amount of $ 1,617.35. UNUM determined this amount by calculating Gallegos's monthly benefit and then deducting the amount Gallegos received in SSDI benefits. According to a document entitled "Detailed Activity Listing" in the claim file, UNUM's notes for August 15, 1995 contain the following claim summary:

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51 y.o. [year old] Director of Marketing disabled due to emphysema, hepatitis, and enlarged heart. SOB [shortness of breath] is main problem — gets exhausted walking one block or climbing one flight of stairs. Also gets heart palpitations. Limited ADL's [activities of daily living]. Clmt [Claimant] is receiving aggressive tx [treatment], and AP [attending physician] notes she has not received MMI [maximum medical improvement], but chances for RTW [return to work] are poor. Clmt has been receiving SSDI [Social Security Disability Insurance] since 6/93, when she had concern. SSDI never stopped when she returned to work from 6/93 to 12/94. Using DOD [date of disability] of 1/20/95, as that is the first time she saw AP after stopping work. Clmt stated she took some vacation because she wasn't feeling well, but didn't see AP right away.

FILE DIRECTION: approving claim and transferring to SRU [Special Risk Unit], as SSDI already in place.

RESOLUTION DATE: present

CONTINGENCY PLAN: there might be a slight chance for RTW but given clmt's multiple conditions affecting her major organs, RTW is unlikely.

(Fohlin Aff. Ex. 18 at CL005.)

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Gallegos applied for and received social security disability benefits in 1993 when she was suffering from breast cancer. Gallegos erroneously continued to receive disability benefits after she returned to work some time in 1993. It appears that she continued to receive disability benefits until October 1995.[1]

As noted above, Gallegos stopped working again on December 16, 1994. On November 7, 1995, Gallegos reapplied for social security benefits. In a January 25, 1996 letter, her application was denied, as the Regional Commissioner of the Social Security Administration found that

> based on a review of your health problems you do not qualify for benefits. This is because you are not disabled under our rules.
>
> * * *
>
> The medical testing showed your breathing capacity is within normal limits. Also, the evidence shows a history of heart problems and breast cancer. Currently, however, the medical evidence has not documented a functionally disabling impairment.

---

1. Gallegos alleged the facts in this paragraph in her 12(M) statement, but her citations to the record do not adequately support the allegations. Nevertheless, because these facts are not material to these motions (and provide some background information), the court will assume the allegations are true.

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> Based on your description of the job of marketing director, we have concluded that you have the ability to return to that type of work.
>
> We have determined that your condition does not keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

(Pl's 12(M) Ex. A at CL150.) Gallegos appealed the decision denying her benefits.

On November 8, 1995, Gallegos telephoned UNUM to tell UNUM that her SSDI benefits had been terminated. Gallegos asked what she had to do to get her check amount changed. On March 8, 1996, UNUM telephoned Gallegos. Gallegos told UNUM that there had been no ruling on her SSDI appeal.

On March 14, 1996, UNUM wrote to Dr. Benson to request updated medical information on Gallegos. UNUM asked for Dr. Benson's assessment of Gallegos's disability at the present time. On April 5, 1996, UNUM received a letter from Gallegos, which included a copy of the SSDI benefits denial letter from January 25, 1996.

On May 13, 1996, UNUM received a letter and medical records from Dr.Benson. In response to UNUM's question about what improvement would be needed for Gallegos to return to work, Dr. Benson wrote "New lungs, a new heart

and a new liver." (Fohlin Aff. Ex. 18 at CL130.) In response to UNUM's request for his prognosis for Gallegos's return to gainful employment, Dr. Benson stated that Gallegos "may return to day [sic] sedentary employment opportunity she could qualify for." (Id.) Additional records were also submitted showing a positive test for Hepatitis C antibodies, a pulmonary function test showing severe obstruction in breathing, an echocardiogram showing "marked left ventricular enlargement" and other abnormalities, and an x-ray from early 1995 showing that the cardiac silhouette had enlarged since March 1994.

On May 29, 1996, UNUM examined a portion of a vocational report that listed the occupational tasks and requirements of a "sales manager."[2] The report stated that the sales manager occupation required "Sedentary Work." On May 31, 1996, UNUM wrote a letter to Gallegos stating:

> This is a follow-up to our conversation yesterday regarding your benefits.
>
> You commenced receiving benefits on July 19, 1995.
>
> Essentially, you remain eligible for benefits for the first 24 months of your disability (July 19, 1997) if you are unable to perform within YOUR occupation as a Marketing Director.

---

2. As Gallegos points out, the report lists the occupational tasks and requirements for a generic "sales manager" position and does not purport to set out the requirements for Gallegos's job or for sales managers in the health care field.

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After 24 months, you remain eligible for benefits if you are unable to perform in ANY GAINFUL occupation.

Your claim came up as part of a routine review. Your attending physician has indicated that you can perform in a sedentary occupation. I have had your job description reviewed by a Vocational Consultant who has advised me that your occupation as a Marketing Director is sedentary.

I am presently reviewing your claim to determine if you can return to work within your own occupation as a Marketing Director. The unique aspects of your job - presentations, are not part of the standard occupation of a Marketing Director. Further, the Vocational Consultant has advised me that Marketing Director occupations (without the unique aspect of doing presentations) would be available in the Chicago area.

Enclosed are the disability contract pages. You indicated that you have the employee booklet. Please review and do not hesitate to contact me should you have any questions.

Please complete the enclosed training, education and employment form and proof of your Social Security resubmission.

(Fohlin Aff. Ex. 7 at 150.)

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UNUM's records indicate that on June 6, 1996, UNUM called Dr. Benson. Dr. Benson indicated that a PFT [pulmonary function test] shows an increase in severe COPD [chronic obstructive pulmonary disease] but that Gallegos could perform a sedentary occupation.[3]

On June 11, 1996, UNUM wrote to Gallegos, stating, in part:

> We are writing in regard to your claim for UNUM disability benefits. Our review has concluded that we are unable to extend benefits.

According to the policy under which you are covered:

"Disability" and "disabled" mean that because of injury or sickness:

> 1. the insured cannot perform each of the material duties of his regular occupation; and
>
> The intent of disability insurance is to provide a benefit if an individual is unable to perform the material duties of her occupation. The difference between an occupation and a job is that an occupation is a vocation or profession as typically performed in the general economy, whereas a job is a set of tasks or work duties performed for a specific employer.

---

3. Defendants contend that Gallegos failed to cite to the record to support her "speculation" as to the meaning of PFT and COPD. However, it is reasonably clear from the file that Gallegos's speculation is correct.

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We have received information from your attending physician, Dr Eric Benson. He has advised us that your present restrictions and limitations are: no limit on sitting, can stand 2 hours a day and can walk 1 hour a day. When asked what his prognosis is for return to gainful employment, he states that you may return to sedentary employment now.

We asked a Vocational Consultant to review the Director of Marketing occupation to determine what level of exertion is needed to perform in that occupation. The Vocational Consultant advised me that the occupation is sedentary and that these occupations would exist in the Chicago, Illinois area.

Therefore, you are no longer disabled according to the above definition, and we must deny liability as of presently.

If you have new, additional information to support your request for disability benefits, please send it to my attention at the above address.

If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice to:

UNUM
LTD Quality Review Section
2211 Congress Street
Portland, ME 04122-0360

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> Please be sure to include your Social Security and policy numbers. Your written request should include your comments and views of the issues, as well as any documentation you wish UNUM to consider. You may also request copies of pertinent documents contained in your file. If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

(Fohlin Aff. Ex. 13.)

On March 20, 1997, a hearing on Gallegos SSDI appeal was held before an administrative law judge (ALJ). On April 10, 1997, the ALJ issued a written decision finding that Gallegos was disabled and awarding her benefits. The ALJ found that Gallegos's "past relevant work was sedentary as the director of marketing for hospital clinics, as the assistant director of a day care center, and as the associate trainer for an educational organization." In finding that Gallegos was disabled for the purposes of SSDI, the ALJ credited the testimony of medical advisor Dr. Carl Leigh. It appears that Leigh reviewed Gallegos's medical records but never examined Gallegos.

On April 18, 1997, M. Jacqueline Walther, one of Gallegos's attorneys for the social security claim, wrote to UNUM. The letter informed UNUM that an administrative law judge had awarded Gallegos benefits and enclosed a copy of the decision. In addition, the letter stated, in part:

> At the time of your letter, you indicated that if there was additional information to support Ms. Gallegos's request for benefits, it should be sent to you. We are acting under that provision.

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> I see from your letter that there was a sixty-day review period under the policy. However, the administrative law judge's decision was only issued this month and, therefore, was not available previously.
>
> We note that the judge finds that, for purposes of Social Security, Ms. Gallegos has a condition which equals the listings under the Social Security regulations. This means that she is, in Social Security's view, incapable of performing any gainful activity. This is a far broader definition of disability than that contained in UNUM's policy. Additionally, the judge finds that Ms. Gallegos's disability began, for purposes of Social Security, December 16, 1994.
>
> Under these circumstances, we would ask that you not only reinstate Ms. Gallegos on benefits prospectively, but give her benefits back to the date she was terminated.

(Fohlin Aff. Ex. 14 at CL77.)

On June 4, 1997, Gallegos telephoned UNUM. She told UNUM that she had no new information and had not seen a physician since July 1996 "because her income was stopped." UNUM explained that it had been more than 60 days since UNUM's decision, and that it was going to be difficult to support a disability claim if Gallegos had not seen a physician since July 1996.

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On July 9, 1997, Mark DeBofsky, the attorney for Gallegos in the present action, wrote to UNUM requesting that UNUM reopen Gallegos's claim. DeBofsky attached a copy of the ALJ's ruling and the notice of award from social security. DeBofsky also enclosed records and reports from Dr. Benson. DeBofsky requested a copy of Gallegos's entire claim file. In addition, DeBofsky expressed his belief that Gallegos's occupation "most closely resembles the occupation characterized by the U.S. Department of Labor, *Dictionary of Occupational Titles* as 'public health educator'. . . . which according to the DOT, is performed at the light level of exertion."

On July 31, 1997, UNUM wrote to DeBofsky about Gallegos's claim. The letter stated in part:

> Your claim was denied on June 11, 1996. At that time we indicated that if you wished to have your claim denial reviewed that you must submit a request for review within 60 days from your receipt of the letter. Your present request for review is well beyond this 60 day deadline. Because of the untimeliness of your request, we cannot review your claim and must uphold the denial of benefits.

(Fohlin Aff. Ex. 17.)

Gallegos filed the present lawsuit on September 3, 1997, alleging that the defendants wrongfully denied her LTD benefits. The parties filed cross-motions for summary judgment.

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DISCUSSION

Summary judgment is appropriate where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). A genuine issue for trial exists only when "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986).* The evidence must be considered in the light most favorable to the nonmoving party and all inferences must be resolved in that party's favor. *Vitug v. Multistate Tax Comm'n, 88 F.3d 506, 511 (7th Cir. 1996).*

Gallegos argues that she is entitled to summary judgment because the record shows that there was no legitimate basis for UNUM to terminate her claim for benefits. The defendants argue that they are entitled to summary judgment for four separate and independent reasons: (1) Gallegos failed to appeal her denial of benefits within the 60-day time limit for appeals; (2) in determining that Gallegos was capable of sedentary work, it was reasonable for UNUM to rely on the medical opinion of Gallegos's attending physician; (3) Gallegos failed to provide UNUM with the requisite proof of regular attendance of a physician, as there was no evidence she had visited a physician since June 1996; and (4) Gallegos failed to provide UNUM with any proof of continued disability, as her April 1997 appeal contained no medical data more recent than June 1996. Because this court finds that defendants are entitled to summary judgment based on Gallegos's failure to appeal in a timely manner her denial of benefits, this court does not address the defendants' alternative arguments.

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As an initial matter, this court will discuss the appropriate standard of review. The Supreme Court has held that "a denial of benefits under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989).* If the plan gives the administrator or fiduciary discretionary authority, then a court must review the decision denying benefits under the arbitrary and capricious standard. *See Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 378-80 (7th Cir. 1994).* A plan need not contain an "explicit" grant of authority in order for a discretionary standard to apply. *Id. at 379.*

Here, the Plan provides that

> when the Company receives proof that an insured is disabled due to sickness or injury and requires the regular attendance of a physician, the Company will pay the insured a monthly benefit after the end of the elimination period. The benefit will be paid for the period of disability if the insured gives to the company proof of continued:
>
> 1. disability; and
>
> 2. regular attendance of a physician.

The proof must be given upon request and at the insured's expense.

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The language is similar, though not identical, to language that the Seventh Circuit has found to give discretion to the plan administrator. In *Patterson v. Caterpillar, Inc., 70 F.3d 503, 505 (7th Cir. 1995),* the Seventh Circuit found that the language "benefits will be payable only upon receipt by the Insurance Carrier or Company of such notice and such due proof, as shall be from time to time required, of such disability" afforded discretion to the administrator. In *Donato,* the plan provided that the administrator "will pay long-term disability benefits 'upon receipt of proof,' but that 'all proof must be satisfactory to us.' " *19 F.3d at 379.* The requirements of "due proof" in *Patterson* and "satisfactory" proof in *Donato* indicate a discretionary determination by the administrator as to the adequacy of the proof. Here, because the Plan requires only "proof," rather than due proof or proof satisfactory to the administrator, it can reasonably be argued that the Plan does not afford the administrator the same discretion.

Despite this difference, three courts in this district and another in this circuit have found that the requirement of "proof" in UNUM's disability policies reserves discretion to determine benefit eligibility. *See Wyatt v. UNUM Life Ins. Co. of America, 1999 U.S. Dist. LEXIS 2442,* No. 97 C 8228, *1999 WL 116213,* at *5 (N.D. Ill. March 2, 1999); *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 979 F. Supp. 726, 729 (N.D. Ill. 1997); Infantino v. Waste Management, Inc., 980 F. Supp. 262, 266 (N.D. Ill. 1997); Bollenbacher v. Helena Chem. Co., 926 F. Supp. 781, 787 (N.D. Ind. 1996).* In *Perlman* and *Infantino,* the courts found that *Patterson* was binding precedent that required application of the arbitrary and capricious standard. Courts

in other districts have reached contrary results. *See, e.g., Tavares v. UNUM Corp., 17 F. Supp. 2d 69, 76-77 (D.R.I. 1998); Williamson v. UNUM Life Ins. Co. Of America, 943 F. Supp. 1226, 1228-29 (C.D. Cal. 1996); Holsey v. UNUM Life Ins. Co. of America, 944 F. Supp. 573, 577 (E.D. Mich. 1996).* This court need not resolve this question, because even under a less deferential standard of review, the administrators were clearly justified in refusing to permit Gallegos to appeal the decision denying LTD benefits.

ERISA is silent on whether exhaustion of remedies is a prerequisite to bringing an action under *29 U.S.C. § 1132*(a)(1)(B). However, the statute does require plans to employ a claim and appeal procedure. Section 1133 provides that

> in accordance with regulations of the Secretary, every employee benefit plan shall —
>
> > (1) provide adequate notice in writing to any participant or beneficiary whose claim . . . has been denied, setting forth the specific reasons for such denial . . . and
> >
> > (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. The regulations specify that "[a] plan may establish a limited period within which a claimant must file

any request for review of a denied claim. Such time limits must be reasonable. . . . In no event may such period expire less than 60 days after receipt by the claimant of written notification of denial of a claim." 29 C.F.R. § 2560.503-1(g)(3).

Although ERISA does not explicitly require exhaustion, the Seventh Circuit has held that "a district court may properly require the exhaustion of remedies before a plaintiff may file a claim alleging the violation of an ERISA statutory provision." *Robyns v. Reliance Standard Life Ins. Co., 130 F.3d 1231, 1235 (7th Cir. 1997).* The Seventh Circuit has identified several reasons for requiring exhaustion:

> Congress's apparent intent in mandating internal claims procedures found in ERISA was to minimize the number of frivolous lawsuits, promote a non-adversarial dispute resolution process, and decrease the cost and time of claims settlement. Plaintiffs would frustrate this intent if they could circumvent ERISA's administrative remedies. Additionally, Congress intended fund trustees to have primary responsibility for claim processing, as evidenced by the specific requirement in § 503, *29 U.S.C. § 1133,* of a claim and appeal procedure for every employee benefit plan. To make every claim dispute into a federal case would undermine the claim procedure contemplated by the Act. Finally, implementation of the exhaustion requirement enhances the trustees' ability to expertly and efficiently manage their funds by preventing premature judicial

> intervention in their decision-making processes. These advantages outweigh a plaintiff's relatively minor inconvenience of having to pursue her claims administratively before rushing to federal court.

Id. at 1235-36 (quotations and citations omitted).

Here, requiring exhaustion and permitting the Plan to deny benefits based on Gallegos's failure to file a timely appeal would impose more than a "minor inconvenience." Gallegos would be unable to pursue her claim for benefits through the Plan's appeal process or in this court.

Nevertheless, in similar circumstances, courts have applied the exhaustion requirement and upheld appeal deadlines. In *Duffin v. Federal Express Corp., 1997 U.S. Dist. LEXIS 5585,* No. 95 C 3723, *1997 WL 208428,* at *1-2 (N.D. Ill. April 22, 1997), the plaintiff applied for short-term disability (STD) benefits. Plaintiff submitted an STD form to his manager, but the manager forgot to forward the form to the employee disability department. As a result, Federal Express denied STD benefits. In the letter denying benefits, Federal Express informed the plaintiff that he had 60 days to appeal the decision. However, the plaintiff did not appeal the decision for three months, and Federal Express denied the appeal as untimely. The court found that Federal Express's decision was not arbitrary and capricious and upheld the denial of benefits.

In *Villagomez v. AT&T Pension Plan and AT&T Technologies, Inc., 1991 U.S. Dist. LEXIS 747,* No. 90 C

2620, *1991 WL 10657,* at *2-3 (N.D. Ill. Jan. 23, 1991), the plaintiff asserted in 1985 that he was entitled to additional pension benefits. The regional benefits committee never responded to plaintiff's September 1985 letter. In October 1988, plaintiff sent another letter, this time to the committee that oversees the regional committee, including new evidence supporting his claim to additional pension benefits. At the request of the committee, the plaintiff provided further information, but the plaintiff still was not provided with a decision regarding his claim. In January 1990, the plaintiff filed suit. The court granted summary judgment, accepting the defendants' argument that the plaintiff was barred from bringing suit because he had failed to exhaust his administrative remedies. Under the plan, the plaintiff was required to appeal the denial of benefits in writing within 60 days of the decision denying him benefits. Although the defendants never explicitly denied the plaintiff's request for benefits, the court found that, based on the ERISA regulations, the claim was denied when the defendants failed to issue a decision within 90 days. Therefore, once the 90-day period expired, the plaintiff had 60 days to appeal the denial of benefits. Because the plaintiff did not bring an appeal between September 1985 and October 1988, the court agreed that the plaintiff's appeal was barred.

Here, the situation is less complicated than that in *Duffin* or *Villagomez*. UNUM sent a letter to Gallegos on June 11, 1996, informing her that her request for benefits was being denied, giving her specific reasons why her claim was being denied, and clearly providing her with the necessary information to appeal the denial. The letter stated that "should you desire a review, you must send a written request, within

60 days of your receipt of this notice" and that "if UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final." Gallegos did not appeal or otherwise contact UNUM from June 1996 until April 1997.

The Seventh Circuit has indicated that the exhaustion requirement should be excused if the plaintiff can show that (1) there has been a lack of meaningful access to the review procedures; or (2) if exhaustion of internal remedies would be futile. *Robyns, 130 F.3d at 1236.* Gallegos does not argue that either of these justifications is applicable.

Instead, Gallegos raises a number of other arguments why the 60-day deadline should not bar this claim. Gallegos notes that unlike the plaintiff in *Robyns*, who filed suit before administrative review was conducted (and before the claim was actually denied), she attempted to pursue administrative review before bringing suit. However, she did not seek review until at least April 1997, long after the 60-day deadline had expired. Gallegos argues that if this court requires exhaustion, it should merely remand the action or dismiss without prejudice to allow the appeal to go forward. However, by ordering either remand or dismissal without prejudice, this court would effectively eliminate the 60-day deadline for appeals. Gallegos also notes that she "had no legal representation at the time benefits were terminated who could advise her of her rights and the risk inherent in not submitting a timely appeal." Gallegos has not cited any authority supporting her claim that lack of representation is a basis for excusing exhaustion. Here, UNUM's letter clearly advised Gallegos of her right to appeal and the consequences of not doing so.

Finally, Gallegos argues that the 60-day deadline is not found in the Policy or in the summary plan description. While the deadline is not set forth in the Policy, the plan summary specifies that a claimant "may appeal a denied claim within 60 days after you receive the insurance company's notice of denial." (Compl. Ex. A at 28.) In *White v. Jacobs Eng'g Group Long Term Disability Benefit Plan, 896 F.2d 344, 347-49 (9th Cir. 1990),* the plaintiff-appellant argued that the defendants could not enforce a 60-day deadline for appeals of a decision denying benefits because the deadline was not contained in the ERISA plan. The Ninth Circuit disagreed, finding that the defendants could enforce the deadline if it was clearly explained in the plan summary.[4] Here, the deadline is clearly set forth in the summary plan. Furthermore, the letter informing Gallegos that her benefits would be terminated clearly specified that she had to appeal the decision within 60 days. *See Duffin, 1997 WL 208428,* at *1-2 (upholding denial of appeal where 60-day deadline specified in letter). Gallegos failed to appeal and so her claim is barred.

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4. However, the Ninth Circuit found that the notice of termination was inadequate and so refused to apply the 60-day deadline. Gallegos has not argued that the letter informing her that she was not eligible for benefits was inadequate.

Appendix B

CONCLUSION

Gallegos failed to exhaust her remedies by pursuing a timely appeal of the decision denying her LTD benefits. Therefore, the defendants' motion for summary judgment [17-1] is granted. Gallegos's motion for summary judgment [14-1] is denied.

ENTER:

JOAN B. GOTTSCHALL

United States District Judge

DATED: March 31, 1999

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DENYING PETITION FOR REHEARING DATED MAY 26, 2000

UNITED STATES COURT OF APPEALS
For The Seventh Circuit
Chicago, Illinois 60604

May 26, 2000

Before

Hon. JOHN L. COFFEY, Circuit Judge

Hon. JOEL M. FLAUM, Circuit Judge

Hon. MICHAEL S. KANNE, Circuit Judge

No. 99-2022

RITA M. GALLEGOS,

Plaintiff-Appellant,

v.

MT. SINAI MEDICAL CENTER and
UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 97 C 6207

Joan B. Gottschall, *Judge*

Appendix C

ORDER

On consideration of the petition for rehearing and petition for rehearing en banc filed in the above-entitled case on May 8, 2000, by plaintiff-appellant, no judge in active service has requested a vote thereon, and all of the judges on the original panel have voted to deny a rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby DENIED.

Supreme Court, U.S.
FILED
JUL 27 2000
CLERK

(2)

No. 99-2083

In The

Supreme Court of the United States

RITA MORENO GALLEGOS,

Petitioner,

v.

MT. SINAI MEDICAL CENTER and
UNUM LIFE INSURANCE COMPANY OF AMERICA,

Respondents.

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit**

RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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STATUTES

29 C.F.R. § 2560.503-1(g)(3) 6

REASONS FOR DENYING THE WRIT

The question presented by the Petitioner should be rephrased. The question is not whether the Seventh Circuit's decision in this case is in "irreconcilable conflict" with this Court's decision in *UNUM Life Insurance Company v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999); rather, the question is whether the Seventh Circuit was required to even consider *Ward* – a case which rested upon California's notice-prejudice rule – in the absence of such a rule in Illinois. The answer clearly is no. The Petitioner in this case failed to timely appeal her denial of disability benefits and thus failed to exhaust her administrative remedies prior to filing suit in federal court. There was no legally recognizable excuse for Petitioner's failure to exhaust, nor were the Respondents estopped from asserting Petitioner's failure to exhaust as a defense to the Petitioner's suit. *Ward* is simply not an issue, and there is no conflict in the Circuits or an important federal question involved. The Petitioner's request for a Writ of Certiorari to the Seventh Circuit should therefore be denied.

BACKGROUND

Petitioner's "Statement of the Case" omits several key facts. Accordingly, the Respondents have set forth below a brief background which is relevant to the District

Court's and the Seventh Circuit's decisions, and which supplements the facts set forth in Petitioner's Brief.

Ms. Gallegos was employed by Mt. Sinai in a position the Petitioner self-described as "Director of Marketing," and she was insured under Mr. Sinai's Employee Long Term Disability Plan ("Plan"). The Plan was underwritten by UNUM, and provided long-term disability ("LTD") benefits for employees who met the Plan's requirements. UNUM was solely responsible for evaluating claims for LTD benefits and determining each claimant's eligibility for LTD benefits under the Plan. The summary plan description given to Petitioner stated, among other things, that if Petitioner wished to appeal a benefits decision made by UNUM, she may do so "within 60 days after [Petitioner] receive[s] the insurance company's notice of denial. . . . " (App. 3a).

Petitioner stopped working at Mt. Sinai on December 16, 1994. On July 6, 1995, Petitioner applied for disability benefits under the Plan, which was supported by her attending physician's statement that she could not perform any non-sedentary occupation. UNUM awarded monthly disability benefits minus Social Security benefits which Petitioner was then receiving. Petitioner's Social Security benefits were terminated in October 1995. On January 25, 1996, the Social Security Administration ("SSA") denied Petitioner's re-application for benefits, and the Petitioner appealed the decision. (App. 4a).

Petitioner did not inform UNUM that her Social Security re-application had been denied when UNUM telephoned Petitioner on March 7, 1996, to assess the status of her appeal. In fact, Petitioner falsely stated that

there had been no ruling as of that date. On May 13, 1996, Petitioner's attending physician again stated that Petitioner was able to perform sedentary work. (App. 5a). The Petitioner's attending physician again confirmed that Petitioner was able to perform a sedentary occupation during a telephone conversation on June 6, 1996 – just one day after having examined the Petitioner. (App. 25a).

On June 11, 1996, UNUM terminated Petitioner's disability benefits based on, among other things, Petitioner's attending physician's statement that Petitioner was able to perform sedentary work, and the opinion of a vocational consultant that Petitioner's occupation of "Director of Marketing" was sedentary and available in the Chicago area where the Petitioner lived. (App. 5a, 26a). The June 11, 1996 denial letter to the Petitioner included the following statements:

> If you have any new, additional information to support your request for disability benefits, please send it to [UNUM's] attention at the above address.
>
> If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice. . . .
>
> If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

(App. 5a-6a). The Petitioner never appealed UNUM's decision, despite the fact that Petitioner was represented by an attorney who already was appealing her denial of Social Security benefits. (App. 6a).

On April 10, 1997, the SSA reinstated Petitioner's Social Security disability benefits, as of December 16, 1994. (App. 6a). This decision was based on a completely different definition of "disability" than the definition contained within the Mt. Sinai Plan, and on the report of a physician who did not administer any tests to the Petitioner, or perform an examination of the Petitioner. (App. 27a).

On April 18, 1997 – over 10 months after UNUM denied Petitioner further benefits – Petitioner's attorney wrote to UNUM to inform UNUM of the SSA's decision, and to request that the Petitioner's Plan benefits also be reinstated. The Petitioner's attorney provided no new or additional information to support the Petitioner's request for benefits other than the SSA decision. (App. 27a-28a). Moreover, the Petitioner had not seen a physician in the intervening 10 months while she chose not to appeal, contrary to the Plan requirements and leaving UNUM with no recent examinations to substantiate any continuing disability. The Petitioner's attorney did, however, recognize that the 60-day review period had lapsed. On June 4, 1997, the Petitioner telephoned UNUM, and confirmed that she had no new information to give UNUM since UNUM's previous benefits decision, and she also confirmed that she had not seen a physician since July 1996. On July 31, 1997, UNUM told Petitioner that it could not reopen her claim because she had made her request for review of the denial of benefits more than 60 days after such denial. (App. 28a-29a).

Petitioner subsequently filed suit in federal court alleging that UNUM wrongfully denied her benefits. The District Court, finding that Petitioner had failed to

exhaust her administrative remedies by not filing for a review of her claim within the 60-day deadline, entered summary judgment for the Respondents on that ground. The Seventh Circuit affirmed also on that basis. (App. 6a, 15a).

ARGUMENT

Petitioner repeatedly argues that this case "squarely present[s] the issue of *Ward*'s applicability to an ostensibly late-filed administrative appeal." This simply is not the case. *Ward* involved a specific California rule requiring that an insurer show actual prejudice from a delay in filing a proof of claim before it can avoid liability on that basis. This Court found that California's notice-prejudice rule is a "law which regulates insurance," and is therefore saved from preemption by ERISA. Accordingly, this Court held that under the particular circumstances of *Ward*, the insurer could not avoid liability based on a late-filed claim absent a showing of prejudice. *Ward*, 526 U.S. at 363-377, 119 S. Ct. at 1384-1391.

Ward did not, as the Petitioner claims, give "explicit direction to lower courts regarding the issue presented in this case," nor was *Ward*'s holding so broad in its application. Particularly, *Ward* does not establish a general notice-prejudice rule, nor does its holding apply to the facts of this case. In the Petitioner's case, the insurance contract at issue was governed by the law of Illinois. Unlike California, Illinois does not have a notice-prejudice rule, nor has any Illinois court required an insurer to show prejudice for an insured's failure to timely appeal a

benefits decision. *See, e.g., Northbrook Property & Casualty Ins. Co. v. Applied Systems, Inc., et al.*, 729 N.E.2d 915, 313 Ill. App. 3d 457 (1st Dist. 2000); *American Country Ins. Co. v. Bruhn*, 682 N.E.2d 366, 289 Ill. App. 3d 241 (2d Dist. 1997); *Kerr v. Illinois Central Railroad Co.*, 670 N.E.2d 759, 283 Ill. App. 3d 574 (1st Dist. 1996). Federal common law also does *not* require UNUM to show that it was prejudiced by the Petitioner's ten-month delay in appealing the decision to deny further benefits. Where, as here, the Petitioner presented no excuse for the delay, and could not demonstrate any reason why the Respondents should be estopped from asserting Petitioner's failure to exhaust administrative remedies as a defense to her lawsuit, summary judgment for the Respondents was appropriate and was correctly upheld by the Seventh Circuit.[1]

The Code of Federal Regulations sets forth the required ERISA internal review process: "A plan may establish a limited period within which a claimant must file any request for review of a denied claim. . . . In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim." 29 C.F.R. § 2560.503-1(g)(3). UNUM's 60-day internal appeals period is consistent with the Federal

---

[1] Moreover, there is no "overwhelming evidence" supporting the Petitioner's benefit entitlement on appeal as she now claims. In fact, other than the SSA decision which was decided upon an entirely different definition of "disability" and on the report of a physician who never examined the Petitioner or performed any tests on her, the Petitioner presented no new evidence or medical records demonstrating that she was unable to perform sedentary work as her attending physician said she could.

Regulations and is consistent with the holding of *Ward*. This Court found in *Ward* that a longer period within which a claimant can file a request for review, as may be mandated by California's notice-prejudice rule, is consistent with the Federal Regulations. *Ward*, however, did *not* make any judgment that a 60-day period was not acceptable and should not be upheld by the courts, especially where there is no notice-prejudice requirement.

Without a notice-prejudice rule recognized under Illinois law, there is simply no reason why the Seventh Circuit was, or should be, required to consider *Ward*, a case which is simply inapposite to the case now before this Court. Nor has the Petitioner presented any important constitutional question that this Court need consider, or highlighted any split in the Circuits that this Court need address. This is not a question of "exceptional importance" as the Petitioner contends, and thus the opinion of the Seventh Circuit Court of Appeals should not be reviewed by this Court.

CONCLUSION

For all the reasons stated herein, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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